

# Berkeley Lab FY '05 50 OSHA Recordable Cases Root Causes & Lessons

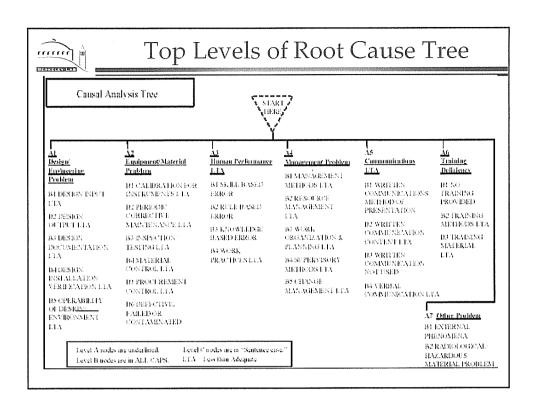
Matt Kotowski & Mike Ruggieri January 9, 2006

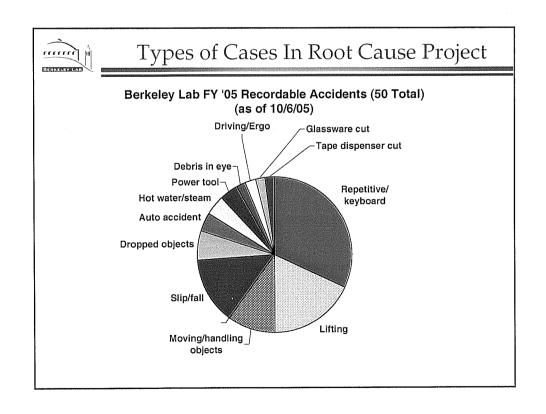


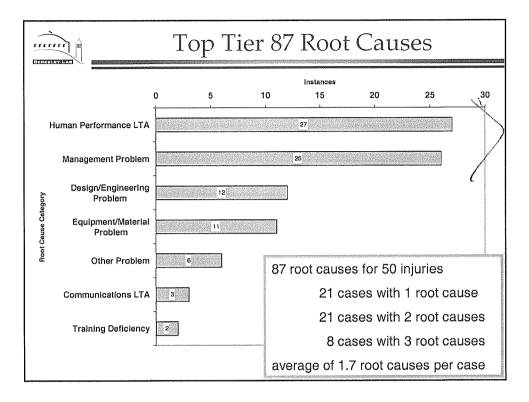
# Background

- Better information for accident prevention is needed
- A Task Force was formed to perform a root cause analysis for all FY '05 OSHA Recordable Injuries
- Task Force members were
  - Richard DeBusk, Safety Manager; Carol Fried, Head, EH&S Division Liaisons; Matt Kotowski, Safety Group; Mike Ruggieri, Safety Group; Weyland Wong, Chair, ES&H Coordinators
- Methodology:
  - » Individual cases were reviewed with the respective EH&S Division Liaison when available, and
  - 3 1 3 root causes were assigned by consensus, utilizing the DOE Occurrence Reporting Root Cause Table

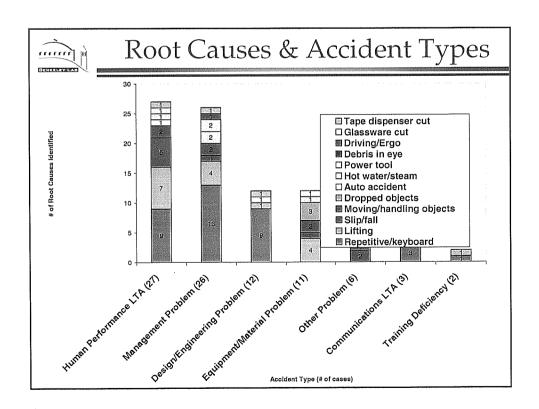
<u>Note:</u> Because the analysis was done in retrospect, with limited ability to verify facts, others might have come to different conclusions in individual cases than the Task Force. But we believe that this is a valid representation of the overall situation.



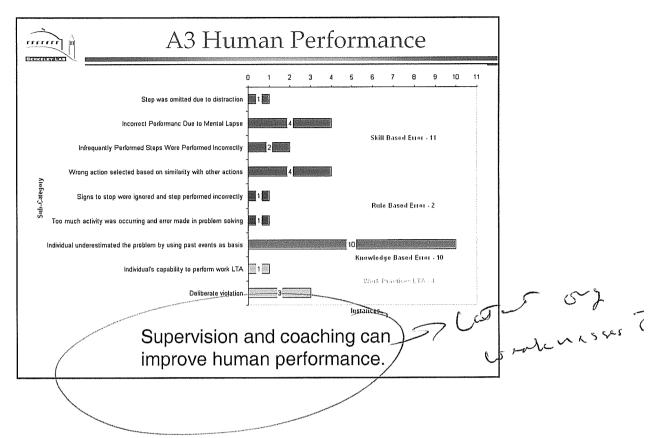


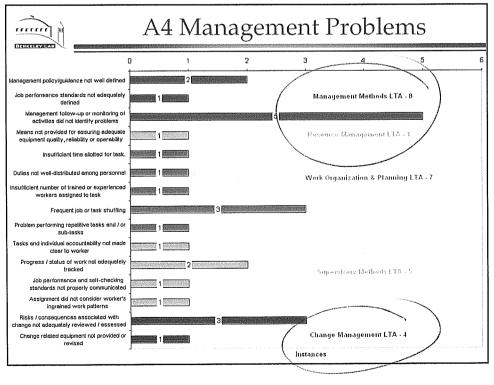


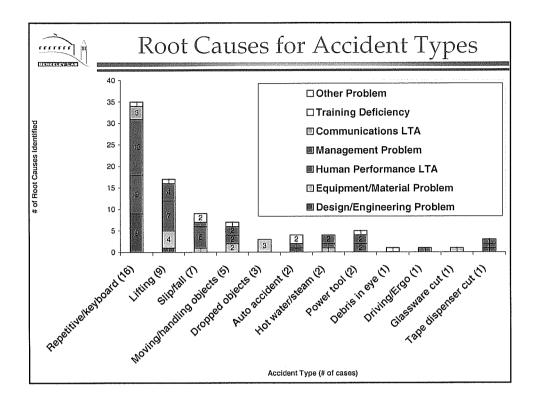
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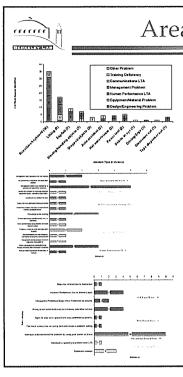




	Repetitive Keyboard Root Cause	S
AT	Design / Engineering Problem	9
A1B5C01	Operability of Design/Environment LTA - Ergonomics LTA	9
• •	1	
A3D1COC	Human Performance LTA Skill Based Error - Wrong action selected based on similarity with other actions	1
A3B3C03	Rule Based Error - Signs to stop were ignored and step performed incorrectly	1
A3B3C06	Knowledge Based Error - Individual underestimated the problem by using past events as basis	6
	Work Practices LTA - Individual's capability to perform work LTA	1
Α4	Management Problem	13
A4B1C02	Management Methods LTA - Job performance standards not adequately defined	1 2
A4B1C04	Management Methods LTA - Management follow-up or monitoring of activities did not identify problems	2
A A E COR	Resource Management LTA - Means not provided for assuring adequate equipment quality, reliability	1
A4DZC00	or operability	•
A4B3C02	Work Organization & Planning LTA - Insufficient time allotted for task.	1
	Work Organization & Planning LTA - Duties not well-distributed among personnel	1
	Work Organization & Planning LTA - Frequent job or task shuffling	2
A4B4C02	Supervisory Methods LTA - Progress / status of work not adequately tracked	1
A4B5C04	Change Management LTA - Risks / consequences associated with change not adequately reviewed /	3
	assessed	
A4B5C10	Change Management LTA - Change related equipment not provided or revised	
	Communications LTA	3
A5	Verbal Communications LTA - Suspected problems not communicated to supervision	· · · · · · · · · · · · · · · · · · ·
ADD4006	Astral Coltininations FLV. Sasherred broblesus not continuingered to subsidiately	J.
A6	Training Deficiency	1
	Training Methods LTA - Refresher training LTA	1

	Lifting Root Causes	
A1	Design / Engineering Problem	1
A1B1C03	Design/Engineering Problem - Design input not correct	1
A2	Equipment / Material Problem	3
A2B4C01	Material Control LTA - Material Handling LTA	3
A3	Human Performance LTA	7
A3B1C03	Skill Based Error - Incorrect Performanc Due to Mental Lapse	1
A3B1C04	Skill Based Error - Infrequently Performed Steps Were Performed Incorrectly	1
	Skill Based Error - Wrong action selected based on similarity with other actions	1
A3B2C03	Rule Based Error - Too much activity was occurring and error made in problem solving	1
	Knowledge Based Error - Individual underestimated the problem by using past events as basis	2
A3B4C02	Work Practices LTA - Deliberate violation	1
Α4	Management Problem	4
A4B1C04	Management follow-up or monitoring of activities did not identify problems	1
A4B2C08	Resource Management LTA - Means not provided for assuring adequate equipment quality, reliability or operability	1
A4B4C02	Supervisory Methods LTA - Progress / status of work not adequately tracked	1
A4B4C06	Supervisory Methods LTA - Job performance and self-checking standards not properly	1
A6	Training Deficiency	1
A6B2C01	Training Methods LTA - Practice or hands-on experience LTA	1

· · · · · · · · · · · · · · · · · · ·	Slip / Fall Root Causes	
Α2	Equipment / Material Problem	1
A2B3C02	Inspection/Testing LTA - Inspection/Testing LTA	1
А3	Human Performance LTA	5
A3B1C03	Skill Based Error - Incorrect Performanc Due to Mental Lapse	2
A3B1C06	Skill Based Error - Wrong action selected based on similarity with other actions	1
	Knowledge Based Error - Individual underestimated the problem by using past events as basis	1
A3B4C02	Work Practices LTA - Deliberate violation	1
A4	Management Problem	1
A4B1C01	Management Methods LTA - Management policy/guidance not well defined	1
A7	Other Problem	2
A7 Indet.	Indeterminable	1
A7 NP	Not Preventable	1



### Areas Needing Attention

- Managers & Supervisors
  - » Computer ergonomics
  - » Provide clear directions
  - Good work planning
  - Better supervision

#### Individuals

- » Computer ergonomics
- Attention to details (skill based errors)
- » Don't jump to conclusions (knowledge based errors)



## Conclusions for Top Injury Types

#### Repetitive Motion Injuries

- Work involving repetitive motion activities needs to be better planned, executed and managed.
- Some employees are underestimating the risks of musculoskeletal injuries and consequently are trying to work through discomfort, resulting in more serious injury.

#### Lifting Injuries

- Although trained, some employees underestimate the risk of injury related to lifting and fail to follow learned lifting practices
- Managers need to monitor employee lifting practices and verify that correct material handling practices are employed consistently.

### Slip/Fall Injuries

Some employees are not sufficiently attentive to their footing when walking or climbing.



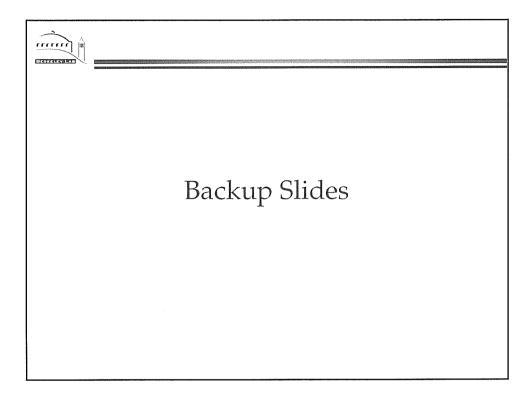
### System Lessons

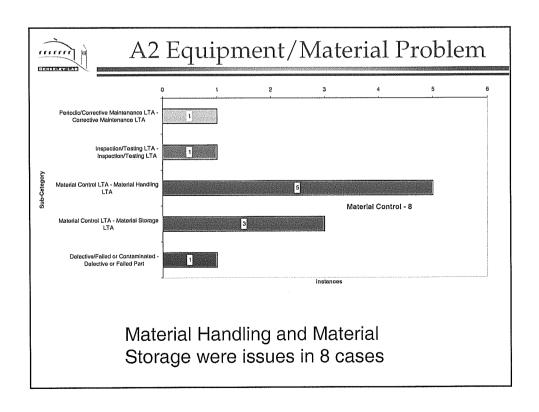
- Supervisor and Investigator reports do not formally identify root causes.
- Corrective actions identified usually address the most proximate cause, not root causes.
- Training deficiencies are not a significant problem at LBNL

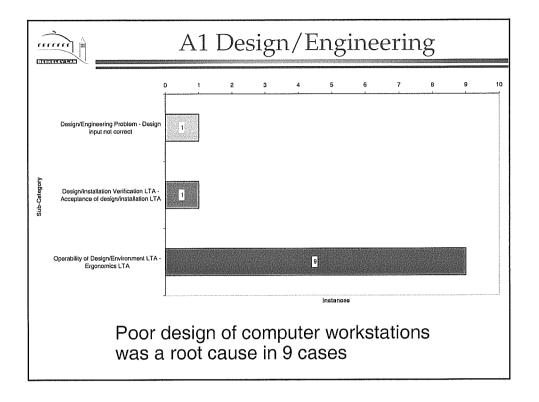


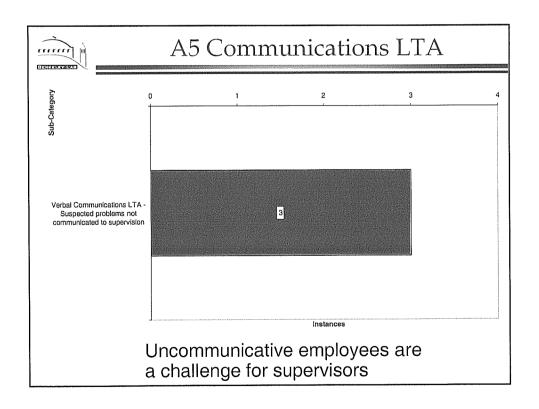
## Path Forward For System Lessons

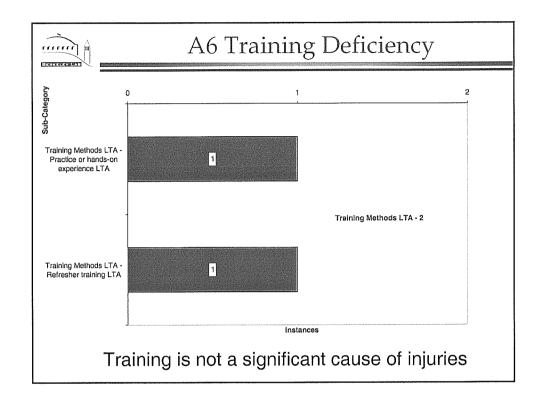
- Select a root cause investigation methodology for LBNL.
- Require root cause determination for all incidents by coordinators and liaisons.
- Review all root cause determinations for adequacy soon after the determination is made, when changes are still possible.
- Require that corrective actions address root causes.

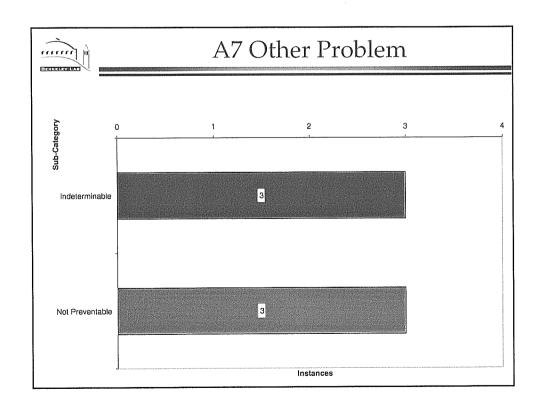












		Incidents & Roo	T C	au	ses	s, p. 1
No.	Туре	Description	Root Cause 1	Root Cause 2	Root Cause 3	Justification for Root Causes
19	accident	Employee was driving a Lab vehicle in the No. 4 Jane on southbound 650. He was going to a job size in Fremont to collect data from a monitoring instrument. At a location approvimately 1 mile not of the Moving of family, his vehicle was struck by prother vehicle. He suffered minor cuts and advantages and book with or so in the left side.	A7 Hot Preventable			Was struck by other car on freewar not preventable by CBNL
5		Employee was running for a ous and ran out from detween garked cars into the path of an oncoming wentide, which ran over har foot. Sha suffered broken bones	A155002	A951002		Poorly designed traffic layaout and employee did not stop to lock for traffic before stepping into traffic lane.
14		Employee was grinding at the Molecular foundry, using safety glasses and face sheld. On the way home, he noticed that something was imitating his eye, and he want to Kaiser for Ireatment.	A7 Indeterma #bl4			Insufficient data to make a reliable root cause determination
29	Driving/E rgo	Employee states " pain in the left shoulder, arm and hand, thumb and index finger was manifested for the first time. Couldn't drive later in the day."	A483C10			Route involves repetitive luming & neck luming
,	Diopped objects	Employee was aligning a hinge pin during steel erection, when the pin suddenly fixed up and dropped into piaces, pinching the employee's finger in the process	A254C01			Employee handled pin in a manne which did not preclude injury when the pin fell into place as it was supposed to
??	objects	Employee and co-worker were working on guardrays near outding 9. White lifting a section, another section fell on employee's steel toed safety poots, cuncturing inrough the rupber and causing a laceration that required 4 surries.	A254C02			Inappropriate stacking by others a few days earlier
17	Dropped objects	Employee was transferring lead bricks wrepped in varyl lape from a kill face to a shelf. A lower brick abhered to the brick he was moving sufficiently to be distinged from the table and it felf from a height of approximately 30° on to his night foot. Employee was waiting steal-tool foot protection and leather gloves. The impact on his foot occurred above the toe box and resulted in a metatersal fracture.				Supervisor identified that cart should have been closer to shelf
1-1	e cut	Was washing a small (100-160 mil) deaker with a scrub sponge using nis right thumb and first and second lingers to reach down inside the beaker was cut on the right 4th digit on the distall side by a broken edge on the 4b of the beaker.	A256001			Entidoyee did not notice defect in glassware until he had out himself. Glassware was inherited from othe lab
7		Employee was semblying a pan of hot water from a steam table and suffered a burn to the back of the right hand when some of the water spashed.	A483008			Magnagement routinely required workers to lift and move open trays with scalding hot water.

		Incidents & Roo	t C	lau	ses	s, p. 2
Vo.	Туре	Description	Root Cause 1	Root Cause 2	Root Cause 3	Justification for Root Causes
2	water/ste am	Employee was performing routine maintenance on a steam cleaner. Half an now into the procedure is fitting failer, causing the cleaning wand to fit packwards, burning the employed's light side with steam. Preliminary information indicates that the nozzle was partially corroadd and plugged causing an excessive cressive build-up which led to the failure of the fitting.	A581004	AAB3CCF	A282003	Employee attempted to repair a hazardous, defective piece of equipment ha was not familiar with Management had not provided competent replacement for senior employees who were lambla with the equipment that had retired or pean late of
	1	Employee was attempting to move a compressed gas cylinder by pulling up on the protective cap. The cap came loose and squark him in the mouth cracking a tooth, which required a root canal and guin surgery.	A3E3C00	A082C01		Both employee and supervisor were unaware that cylinders may not be inoved by litting or culting on the cylinder cap.
	Litting	Employee was pracing a spin coater back into a Laminar flow hood and felt pain in his tower back on 19/2004. Spin coater is estimated to wage 80 lbs, and is 3/2000 He lifted the spin coater up - 30% from the floor into the flow hood and placed if though the notes in the flow hood to its resting position.	A381004	A181003		Englosers should have been designed with removable panel, to allow unit to be slid in and out, rather than requiring lifting.
		Two employees were moving tables from a contenence room to the outer half afea as cer a client's request. The table (72" long x 42" word was filted in the open, up right position and candid out through a set of obtaile doors. When the table was set back down on the floor, it supportlegs no one size collapsed and the table fell on the employee's left floot brusing the great toe. Employee was not wearing safety shoes.				Facilities purchased poor quality lables, had no mechanism for inspecting tables placed into conference looms.
	Lifting	Employee suffered a nerna from performing routine carcenter work over a centro of time. Gould not lead a store for stance, but the pain had goden worse and the surgery was done on an emergency basis.	A284001	A484002		Material handling technique inadequate plus matrix supervisor was aware of discomfort and did no intervene
2	Litting	Employee suffered a polarisal upper arm and anounter sprain while filting heavy files mand out of a file column. This involved reaching buyond ren mornal range of motion and filting file follows weighing up to 7.5 pounds with a thickness of 4 inches on a repetitive/fairly basis.	A381000	AAB1004		Employee exceeded her physical capabilities, and management did not notice the problem unblinjury had occurred.
11	L: Aing	Preliminary report based on the Doctor's report from Russer Castland which states that the employee injuried his low book white stilling a heavy centrifuge from . Was deated at Kasser Castland and given prescription medication.		A982003		Employee was standing too far from rotor to safely lift it, and employee was rushing.
7	Lifting	Employee was lifting a crate with poworker from a table 3" tall to the scale 0" off the ficor. Lifted it and placed to nithe scale and the fixed it back onto the table. Pet no pain that day and then on Saturday and Sunday fall or an and went to Kaiser Valler for treatment.	A381003			Lifting equipment was available, amployees chose manual lifting
2	Liking	Employer injured her right ahouder on 35000 while motioning the floors and emptying the trash (2 CO-10 300M). She was seen by her own PMD on \$4305 and prought the medical information to health Services on \$7400.	A451000	A283000		Employee did not understand that previously communicated instructions to dump map water into floor grain applied to her.

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No.	Туре	Description	Root Cause 1	Root Cause 2	Root Cause 3	Justification for Root Causes
36	1 '	The employee was lifting a compressor out of a cardboard dos. The compressor was wedged in styrofoam packing material so the employee used a twisting motion to free and lift the equipment from the box. The amployee fell lower back own on his right side after lifting the compressor.	A234001			Unable to determine whether employee's choice of method was reasonable or not. Weight with or without box was reasonable.
13	andling	Employee stepped on a door set while carrying a 25 los power supply, and the outer metatars at bone in his left foot cracked. Employee was wearing new safety boots. He had previous fractures to the foot from a motorcycle accident 10 years earlier.	A7 for Preventable			Personal medical problem aggravation of preexisting medical condition
	andling orjects	Employee and covored were stiding a 20% to pacytic date intext2Tricks on its edge across the bilinoom floor to store in heat to the custoding's sink. As they fined to make the furn between the hand washing station and the unite, the prise stopped and fell on the employee shall foll. Safely shots strevented a more serious injury, but the plate brussed the employee's metabase area Employee now requires physical therapy.	A284002			Management failed to provide adequate storage facilities in B-59
2-1	andling objects	The employee stated he was descending down the stativity hear building T I with a recycle on full of paper, when he lost control of the bin. He grabbed he bit to with his right hand dying to stop a from falling down the statis when he strained his right index incides and ring singers. The employer stated he bit could of weighted between 190 and 200 pounds.		A484011		Employees feel pressure to complete work rapidly regardless or safety instructions to the contrary
20		The employee stated she was trying to stop a coor from closing when she jammed her right frumb on the door.	A321009			There is no defect in the door or the door mechanism that contributed to this incident.
28	Moving/n andling objects	Employee walked into a prohuding piece of 4x4 angle von, preaking the 5th metatarsal bone in his right foot	A284C02			Material was stored in an inappropriate manner. Insufficient information to determine why and how.
39	tool	Plumbar was operating a M21 of ill most with a flotarn hole saw. He was using the too to drift through a sheet matal stud when it bound up and twisted out of his grasp ir estiting in a firstone to the 4th metacarboa bone of his right hand.	A384C02	A491001	AA54C01	Employee was using a tool from which the required safety handle had been removed in the presence of a supervisor who did not object into unsafe practice.
40		Employee states that he was using a 1/2" only motor with a 2" hole saw. While string sheehook the drill motor hit some backing in the wall that caused the motor to twist and it twisted his left hand	A7 indetermo			Insufficient data to make a reliable root cause determination
4	e/keybos	Employee was under intense pressure to create a rejicit. She had just gotten a new laptop, and ord not have an external mouse or docking station for a yet. She used in all day in meetings on Priday. (On Saturday has woke up and ner right narrowns were swotten, patiett, and unusable.)	1A493C08	A233006		Assigned to work on new laptop all day will poor ergonomics, employee tried to work forough pain
7	e/keybog	White inputing information from margropy documents into an institutional computer database system, employee solely used her left thumbland index finger to furn the individual sneets of daper over. This motion eventually caused the thumb cerdion to catartifate upon fissing the digit.	A383C00			Employee did not recognize that st was using her thomb in an ergonomically inappropriate manner

III.	and Till	Incidents & Roo	ι <u> </u>	au	<i>3</i> C3	γP• <del>4</del>
No.	Туре	Description	Root Cause 1	Root Cause 2	Root Cause 3	Justification for Root Causes
)	e/keybos ra	Employee statted feeling discention on his right should rain forearm in late October 2004. He tried a new mouse on his lown. On December 1st an ergo evaluation was performed at employed's request and adjustments were mode to mis workstation. The pain in the shoulder was resolved, and the arm was recordedly geltling beder. Over the Holiday break the pain got much better, but returned strongly after one day back at work.		A485004	4082003	Changed to mouse intensive software, tried to work through the pain rather than seeking serily intervention, had only CD-ROM training 3 5 years earlier.
15	elke,bca	Employee experienced pain to her left side (chest, arm and hand) when criving the van (2/27/05) and also Bus #2 on (2/17/05). Pain is now going down her left arm from her hack. Referred to go to US HEBINOVINS for treatment and assessment.	A185001	A384C01		Employee suffers from multiple symptoms, some of which are related to her driving of LBAIL.
18	en expos	Employee complained of a resurgence of shoulder pain that had been choosing for several weeks. He went to Health Services early in Fabruary, had an argonomic evaluation, and mate several changes. After an intilla improvement he had a resurgence of pain, and a 2-week course of PT.	A185001			Limited information since ergo assessment was done on campus.
20	e/keybos rd	Employee was complaining of both whisis horting due to computer work. An ergonomic availuation for his workstation was senformed on 3/22 and partitioned in 3/22, but the recommended keypoard tray has not yet arrived. Employee also uses a labtic of allowing. As of the end of April the pain continued and employee is now being treated with prescription medication and physical therapy.	A185001	A431004		inacequate monitoring of ergonomic problems by management
12	Regalitiv efkaybos rd		A185001	A491004	A3B3C00	Rether employed not supervisor knew proper ergonomic position of keyboard tray, now now the control on the tray could be adjusted.
30	Resettiv	Employee suffers from wrist and aboutder pain as a result of working on an argenomically incorrectly adjusted work station	A185001	A485010		Employee with known ergonomic issues worked at an incomplete workstation. Management did not assure workstation was ready wher employee's assignment was changed.
31	Recetity e/keybor id	Over past several months increasing computer work due to a number DOE and other reviews of the Division increased her computer work. Developed increased discomfort in forearms and rest of upper exceeding.	A381000	A481002	A554C06	When workload increased employee did not alert appenvisor to ergonomic discomfort until physical therapy was needed.
25	e/keyboz	The employed is complaining of pilateral whisis, foreamis, and shoulder pain wher repetitive use of poesting white making pilates. She also uses a computer keyboard and mouse. She has point tenderness in both whisis and foreamis.	A185001	A4B3C08		Poorly arranged work space with all of the knee holes under workbench used for storage, making it impossible to work safety
38	Repatity elkayods rd	The employee stated she has claim in her right wrist with numbriess in her right index finger and right mumb after using her computer keyboard and mouse	A353C00	A4BSC01		Employee work habits not in line with good ergonomic practice. heavy added travel work prior to

	1111	Incidents & Roo	t C	au	ses	s, p. 5
No.	Туре	Description	Root Cause 1	Root Cause 2	Root Cause 3	Justification for Root Causes
	e/keybor rd	procedures on the computer prior to jurning the experiment. Has been in this location about 2 weeks. Prior to that he was in Edig. Of where an experiment evaluation was completed and various keybodiat, pointing devices were installed to aliminate right wist cain.				Employee with prior ergonomic issues decided to work on personal lactop computer in the lab even though an ergonomically correct workstalloon had been provided to him in an office.
	e/keybor rd	The amployee in complaining of right foreign elsow, upper iron, and shoulder sear after using net complained and mouse. She is right hand dominant. She has point landamess on har right elsow and upper arm.		:		Recommendations from previous ergo evaluation had not been implemented; i.e., assistant had been hired as recommended, but had not been trained/authorized to assume any of the computer tasks
43		Employee is suffering from vint pain due to computer use. Had an ergonomic evaluation in April started feeling better, now it is viorse.	A185001	A484C02	ASBSC CO	Employee's argonomic conterns were not addressed in a limely manner.
40	erkeybos ra	The employee a completing of right hand bein after using his computer reground and mouse. The started about a most rage. His it replicated commands it Amellia mount of swelling own anotest of the the back of his right hand near the index and middle finger. He has noticed thread movement in this right hand. He works 2 dayswir in putting 50A, and 2 dayswir in building 90 in Luxiannes He also works one daywir attrame. The employee was referred to US Healthworks for treatment, and an exclusion of this north right.		A584C00		Employee falled to report panies a result of computer work to his supervisor until direquired chysica inerapy.
50	Repelity e/keybos	Employee states that he believes the right hand pain stands months ago (\$114.05). He had an ergonomic evaluation about it months ago and all the literis requested have been ordered and installed. Employee states that the right hand pain has improved but holiced pain this AM when working at the computer keybeard.	A125C01	ASB4000	A483C02	Employee failed to report panies a result of computer work to his supervisor until it required physica therapy.
10	Sig/fail	The employee sloped on stars in building 60 A when she fall hiting both whees, right wrist and shoulder. She fall down serven stars and landed at the bottom of the stallway.	A381C02	A283C02		Star variance not discovered during construction 50 years earlier, no history of falls on this stall case, hence also postulate employee misstep.
13	Stip/fall	Employee was despending down the stairs in building 0 when she fell, landing on her ands and linees. Employee was carrying a shoulder pag weighing 3 lbs, but had nothing in her nands.	A3B1C03			No stair defect
16		Employee slipped on a well spot on the floor in the halfway of Blog 74 iresusting in nematoms to hard upon impact with the approximate way and continues to above and whee spon impact with the infoleom floor surface. Water most likely was sprided by someone who had lised a hearty water	AT Indetermin able			insufficient data to make a reliable root cause determination
41		White walking on top of a give of unbundled studs with some debris, the pile shifted, amployee fell and his right hand landed on a SMST nex screw causing a punctura wound.	A394C02	A481001		Management assigned task to random indivisuals without specifying expectations.

		Cause 1	Cause 2	Root Cause 3	Justification for Root Causes
o/lall	According to the Employer's Report of injury, Mr Mallert was in the back of a truck that was loaded with screp metal when he steeped on uneven scrap causing a twisting of the light ankle.	A381000			Employee was properly in bed of truck loading materials into racks
	attended a class at Blog i51 Room 201 (Electroat Hazard) and walked tack down to his office in Latimar Hall Dink. He twisted his left ankle hear the Greek Theater and believes it was due to an Juraven surface. He went to Kaiser Vallety where his left ankle was x-rayed then datted that	Preventable			Employee twisted his foot while walking on an uneven surface on the campus, not under LBNL control.
	the ladder kicked to the side and Mr. Seler felt between the ladder and the concrete wall. When he higher ground, he felt backward, his hard het came off, and he struck is head against a grounding.				Employee selected the wrong ladde for the job
scense tut	The employee works in the Facilities Stores Department and was seeling a pox with tade. While holding the box Reps closed with his right hand, the employee reached for lace with his fell hand. The small finger on his left hand brushed the culting edge of the tage dispenser causing a lacegation.	A481004	A184004	A953C06	Tool improperly installed; unsafe tool not discovered during safety inspections, hexard accepted during years of use.
1	Mail Mail	with scrap metal when he steeped on unavan scrap causing a swisting of the right ankle with scrap metal when he steeped on unavan scrap causing a swisting of the right ankle work. He attended a class stalling of from 201 (Earthern Hazard) and warked back down to his office in Latimar Hall D.14. He twisted his left ankle near the Greek Theater and baleves it was due to an unavan surface. He went to Kalest Valley where his left ankle was right of the casted that the latest ricked to the side and this fear for between the hidden ricked to the side and this fear for between the ridder son the contrate wall. When he hid the ground, he felt between the fill bedder son the contrate wall. When the ground, he felt bedween the clader filled son the fear the bedween the stader son the contrate wall. When the ground, he felt bedween the clader son the contrate wall. When the fear the stade is the scrap has scrip bar mounted against the wall, lacersting he scrip for the employee works in the Facilities Somes Department and was sealing a box with tade. While cases holding the out fleps closed with his right hand, the employee recanced for tace with his felt hand. The small finger on his felt hand busined in ecuting edge of the tage stips related casting a	with acrep metal when he steeped on uneven scrap causing a system of the light acids.  If it is molyge cated this AR to report an injury which occurs on 824-05 at 1,00PM white at work. He attended a class sit Blog 51 Room 201 (Electrocal Hazard) and warked back down in his office in Lethner Hell D.14. He twisted his left and energy the Creek Theater and believes it was due to an uneven surface. He went to Kater Valley where his left and was shraped then casted that the latest closed to the scale of the his three ground, he felt becover the following the sound to the close that the scale close and M.154 aft to between the idead are not be contrate wall. When the high close taked to the scale and M.154 aft to between the idead are not be contrate wall. When the latest closed to the scale and M.154 aft to between the idead are not be contrate wall. When the facilities of the scale of the scal	with acrep metal when he steeped on uneven scrap causing a twisting of the right ankle.  All Employee cated this Aft to report an injury which occurs on 82/10/5 at 14,000M white art work. He attended a class sit Bidg of Foom 201 (Electrocal Hazard) and warked back down in his office in Lethner Hell D.14. He twisted his left ankle hear the Creek Theater and believes it was due to an uneven surface. He went to Kater Valley owher his left ankle was r-rayed then cated that the latest ricked to the side and M. Seler file between the ideater and the contrate wall. When the high ricked to the side and M. Seler file between the ideater and the contrate wall. When the high ricked to the side and M. Seler file between the ideater and the contrate wall. When the high ricked to the side and M. Seler file between the ideater and the contrate wall. When the high ricked to the side and M. Seler file between the ideater and the contrate wall. When the high ricked to the side and M. Seler file between the ideater and the contrate wall. When the high ricked high ricked to the contrate wall when the high ricked high ricked to the contrate wall. When the high ricked high	with acrep metal when he steeped on uneven scrap causing a systing of the light acids.  It is limited a class sit Blog of Room 201 (Electrocal Hazard) and warked back down in his office in Lethner Hell D.14. He twisted his left and energy where he set and between these due to an uneven surface. He want to falser Valley where he set and he was recypted then casted that the latest closed on the falser valley where he set and was expected by Saxool (adder when the latest closed to the sound for the closed to the sound he he set closed to the sound he he had the closed he sound he he had the sound he he had the sound he had the sound he had the sound the latest closed to the sound he had the sound he had the sound he had the sound the sound the sound the sound he had the sound the sound to so the sound he had the sound

